Dr. Carol Longson
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28th February, 2008

Dear Dr. Longson,

Adalimumab, etanercept and infliximab for the treatment of rheumatoid arthritis

Thank you for the opportunity to comment on the further evidence in regard to the above Appeal in respect of:

- Sequential Use of TNF Inhibitors
- Further Cost Effectiveness Analysis of Sequential TNF Inhibitors for RA Patients
- The Effectiveness of non biologic DMARDS after TNF Failure

I must point out that I think it can be extremely challenging for the patient experts to review the documents from NICE as we do not have the health economic knowledge or experts to call upon to interpret the tables and data. However, my comments on the above are:

The review of DMARD use after failure of first TNF identified no direct evidence of initial response to conventional DMARDS. Most of the patients on the Biologics Register have failed at least 3 – 4 conventional DMARDS and clinical practice shows that even after failure of one or two DMARDS including Methotrexate, the liklihood of there being an effective response to another DMARD is substantially reduced.

The review of consequential use of TNFs finds that patients can receive a good response to a second TNF having failed a previous TNF, albeit the response is slightly lower than going from TNF naïve to a first TNF. This is crucially important and I can confirm that in my experience as CEO of NRAS I speak to many patients across the UK on a regular basis and have seen many examples of patients doing extremely well on a second TNF, with a vastly improved quality of life. Equally many UK rheumatologists have now had the opportunity to try patients on second TNFs after either early or late

failure of the first and can testify to the profound benefits that many of their patients have experienced.

NICE moved from not recommending switch in TA36 towards allowing it for patients in whom treatment is withdrawn due to an adverse event before the initial 6 month assessment of efficacy in TA130 - Oct 07 guidance. We believe that there is sufficiently strong evidence now to move to broaden this guidance to include switching due to lack of efficacy at any time following initial TNF commencement. I lost efficacy on my first TNF after having been on it for 3 ½ years. I am now on my third TNF and doing better than on the previous two. There are many reasons why patients would wish to move to a second TNF before going onto either Rituximab or Abatacept (hoping that this will, in due course, be an available option), not the least being related to age. If you are diagnosed at age 26, you have a very long time to live with this painful and disabling disease. As drugs do lose efficacy over a long period, and TNFs may be no different in this respect, having as many clinically effective treatment options in your pathway is vital.

I also understand that the cost per Qaly when using either a second TNF or Rituximab is now very similar which strengthens the argument to give patients the choice.

Hopefully, one day, we will be able to use these effective drugs at a much earlier stage following diagnosis for the small number of patients (by comparison with the total RA population) who have severe, aggressive disease and for whom the prognosis is not good. From the research done, this gives a much better opportunity to put the disease into drug free remission. They are more effective given early than in late stage disease when so much irreversible damage has been done. That said, even in late stage disease they are the only effective option for such patients and remain our lifeline.

On behalf of all those with RA in the UK, I very much hope that you will find in favour of switching when you reconvene.

Yours sincerely,

[redacted]
National Rheumatoid Arthritis Society